

Renewing the practice-knowledge interface

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Summary: Practice is key to professional education. Student reflection and skill rehearsal are by-words of a new Practice Educator role. These are propositions emerging from an initiative to strengthen NHS and Social Care Partnerships with higher education by developing a more integrated model of teaching and learning. This paper describes a method of 'deliberate interpersonal teaching' to amalgamate the relationship between knowledge and practice. It forms the basis of one department's transition to a clinical and workplace focus for teaching that underpins modernisation within one Faculty of Health and its stakeholder partners.

Key words: practice educator, mental health, work-based learning, clinical teaching

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Introduction

The curriculum landscape for education in the National Health Service has changed since the entry over a decade ago of NHS teachers into higher education (UKCC, 1999; ENB, 2000; SCMH, 1997). An imperative for change in mental health care is ever present for NHS and university teachers as the result of health and social care policy initiatives (DoH, 1999a, 1999b, 2000). As a newly formed department of mental health and learning disabilities in 1998, we knew from staff and students after their Project 2000 pre-registration nursing curriculum (UKCC, 1986), about shortfalls in clinical skills, clinical knowledge, and shortcomings in the link lecturer role during the 1990s.

A review by Humphreys, Gidman and Andrews (2000) found that the nurse lecturer's role generally in clinical practice settings had been ill defined and lacked clear consensus regarding the expected outcomes for university lecturers in places where students were being assessed. The teaching outcomes were generalised in terms of students being 'fit for purpose' when qualified after three years of higher education. There was a depreciation of the lecturer's role because teaching in student clinical placements was, in the 1990s, to be shared by lecturers and students' placement mentors, albeit at a risk of expanding lecturer responsibility beyond lecturers' abilities. The change of emphasis from teaching based in NHS schools of nursing to lecturing based in universities meant that there was a likelihood of superficial student and staff relationships with lecturers and complex logistics for educational monitoring. A national study of education and training needs by mental health researchers found that:

There is doubt about the capacity of higher education to deliver the new agenda because teachers lack both clinical credibility and understanding of the new competencies required (Brooker, Gournay, O'Halloran & Bailey, 2000, p.2)

The new agenda refers to the modernisation of the National Health Service in psychiatry, e.g. emphasising prevention and early detection in primary care with community mental health teams, establishing new treatment initiatives, e.g. out-reach services to prevent relapse

for people with serious mental illness, and crisis intervention that could also prevent admission to psychiatric hospital.

It is apparent that there were a number of factors that affected the role of university teaching in mental health practice settings during the 1990s:

- Entry of NHS teachers into higher education
- Requirements to become 'qualified' as academics
- Use of NHS staff during Project 2000 Curriculum
- Task centred nature of clinical practice
- Increased shortages of staff
- Diffused academic management of mental health lecturers
- Deskilling and loss of credibility in mental health teaching

The transfer of teaching from NHS schools of nursing to universities that was completed in the 1990s meant that the new lecturers had to complete undergraduate degrees and/or undertake graduate degrees. The curriculum for this transition was called Project 2000. It entailed a 50-50 partnership in managing the students' progression through a three-year qualifying programme, i.e. a half-weighting to clinical placement experience and half to classroom lecturing.

The subject of Mental Health was represented until 1998 by a team of former NHS teachers, aspiring academics who had been previously split up and managed by nurse academics who more often than not were unqualified in psychiatric nursing. Bringing this subject team into a departmental structure in 1999 was a first step to regain an equilibrium between teaching theory and up-to-date clinical skills, and a momentum for integration into higher education that had been eroded over the previous decade. The momentum was created by a strategy to address our shortcomings, following the formation of the first Faculty and within it departments led by subject specialists.

The practice-knowledge relationship

Our new Department found in concluding the Project 2000 (P2K) curriculum in recent years that there was a distant resemblance

Box 1

My aim is to help students to learn through reflective group work and thereby to transact practice from theory and vice versa, for so long a problem in higher education. Working together as a group using clinical practice, as a focus for discussion and learning is familiar to me from my previous working experience in a Therapeutic Community.

I am pursuing a way of teaching and learning whereby students can be helped to learn how to:

- Open up their clinical work for exploration and discussion
- Make links between their clinical experiences and relevant theory
- Reflect on the nature of their relationships with service users
- Develop an ability to actively participate in a group, facilitating their own learning and that of their peers

The group is one structure for teaching and learning that concentrates on interpersonal and relationship skills. Thus the group builds on and adds to the University College-based learning that takes place in the Interpersonal Relations Module during the Common Foundation Programme that comprises the early part of the nurse education programme.

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between the learning situation in higher education and the situation in which the learning was to be applied in practice. What was prescribed to be taught in the curriculum fell short of what was, from an NHS point of view, useful for mental health students in clinical practice. This became all too apparent after the three Practice Educators (co-authors) were in post during 2004.

It's not just that information about knowledge and practice needed to be better understood, assimilated, and retained – the resultant gap in that relationship created a dissonance, or difficulty, in acquiring skills, due to a reduction of opportunities in the P2K curriculum for psychiatric experience. The application of theory and knowledge to practice was not sufficiently well taught because the curriculum itself was not sufficiently focused on the clinical skills needed in practice to address the needs of mentally ill people. The Project 2000 curriculum had marginalised mental health learning and practice. The impact of

P2K was therefore out of step with the NHS modernisation agenda during the 1990s, referred to above by Brooker *et al.* (2000)

By contrast, the practice educators are the new agenda staff, recruited from clinical settings where child, family, and adult mental health services have been implementing inter-professional assessment, developing and using assertive outreach skills, and then infusing the department, their teaching, and clinical mentors with this background and recent experience. The practice educators have shown us how knowledge for practice is created and used in practice and how they can generate and critique this knowledge. In mental health care we are cognisant that fitness for purpose arises from building upon the knowledge of the student and the teacher. Evidence to inform practice arises from personal knowledge and the skills cultivated on the practice educators' individual frameworks. This is what Freire (1985) and Polanyi (1958) would call a framework of personal evidence based upon personal professional knowledge and experience. What teachers and mentors transmit to students combines with individuals' personal ways of knowing to present options for thoughtful professional responses to service users, rather than intuitive reacting, to their needs.

The practice education methods that we now use are emblematic of our changes in teaching and learning, at the centre of which is the lecturer practitioner in practice education. Whilst these new posts entail a considerable increase in departmental mentoring, supervision, and apprenticeship in teaching, the three practice educators have established a methodology that involves client-centred learning and interpersonal teaching (exemplar in Box 1). Client-centred learning has developed in what you might consider to be a modified form of the problem based learning method (after Boud & Feletti, 1991). However, learners are not given preset cases in advance with references for further reading and questions to prepare in small groups. Complete and actual cases are elicited in small student groups, in real scenarios initiated by the students in clinical settings.

Organisation of knowledge in practice learning

The relative subjugation of psychiatric conditions of illness in the implementation of Project 2000 was a cause of concern for staff and students when in 1998 we set about analysing how to take the new department forward. The mental health team had also been subjugated, or diffused, within general medical nurse teaching. In addition, there has been a growing cause for concern about clinical teaching by NHS staff and understandably so: NHS staff juggle the competing demands of clinical service, administration and management, training and supervision of students, and the demands arising from recruitment shortfalls, to name a few of the many factors that impinge upon their teaching, mentoring, and student assessments. They also have strong feelings about their role as nurses and the impact on their role from such on-going effects as organisational changes and increasing student numbers.

According to Eraut (1994) and Higgs and Titchen (2001), the knowledge of practitioners is based on personal knowing through professional and life experience along with professional craft knowledge, as well as knowledge gained through higher education study and research. In our transition to a department with a clinical focus on skill acquisition, we find that practice educators' facilitation of student learning results in a deliberate reflective process that involves thinking about thinking – deliberate consciousness-raising and critique. In these group teaching sessions, practice educators help students, and in groups for qualified staff, bring their knowledge base under critical review, individually and among peers. This is what we call deliberate interpersonal teaching, a deliberately rather than ad hoc reflexive process enabling learners to use their case-based experience to fortify the interplay in their relationship between knowledge and practice.

A need for practice education has brought us to client-centred learning and interpersonal teaching. For clinicians and teachers to be with the students in a way that they would wish the students to be with service users, these methods which we will now discuss need to be deliberate, overtly a part of consciousness in the teaching. This means being overtly aware of using for example:

- Bolby's attachment theory [for students at all levels it is helpful in understanding relationships, to differentiate the way that we

- are attached/attuned to each other and yet autonomous while attachments based on dependency can be a debilitating handicap], as does bringing Erikson's theory of consciousness [different stages in life which affect relationships on the basis that basic conflicts can be anticipated so the students learn that by taking thought they can become conscious that they are conscious in regard to psychosocial stages] (Rayner, 1986).

The Practice Educators' teaching, from pre-registration year 1 nursing students 'upwards' to year three diploma and BSc students, is explicitly sculpted to suit the students' experience so that their understanding and ability is exponentially evident to them over time. In client-centred learning, students move beyond the problematic scenario basis of practice learning postulated by Boud and Feletti (1991).

The practice educators are lecturer practitioners who spend 3-4 days per week in clinical settings. Particularly in these early years of the Practice Educators' postgraduate studies for teaching qualification, the other lecturers and senior lecturers in the department carry an extra weight of responsibility in terms of the mentoring and higher education support needed by practice educators. A teaching and learning context for enabling students to link practice to theory is discussed below in the section entitled deliberate interpersonal teaching. As a preface to that section of the paper, the approach within student groups is expressed in Box 2 overleaf.

Deliberate interpersonal teaching

In our experience there is a direct link between the time spent practising thinking about a skill and a level of capability to develop that skill. The quantity of time spent is not the only factor in achieving informed skills; the quality of this time is at least as important, that is, the development and maintenance of client-centred learning requires time dedicated specifically to the improvement of skills through deliberate interpersonal teaching (Box 3 and 4). This concept is highlighted by the difference between the musician who plays in a concert at the music hall for hours each day and the musician who spends hours practising the fingering of

Box 3

Reflective practice/working in groups – a teaching and learning activity: Acquiring the skills for engagement in therapeutic relationships is the cornerstone of psychiatric and mental health nursing. Helping students learn to analyse their nursing experience through group work forms part of a developing culture of reflective practice at an NHS Trust-wide level.

It is clear in this work that good interpersonal skills are essential to effective psychiatric and mental health nursing. It is essential that student nurses learn how to form, develop and sustain therapeutic relationships with service users. Relating closely to them requires an ability to be open to their distress, pain and fragmentation. In order to acquire the relevant skills and abilities to achieve this aim, I have adopted a teaching and learning strategy that is focused on the development of self-awareness and promotes engagement with feelings. The student nurses are enabled to come together as a group to acquire insight and understanding by sharing their common experiences.

It is essential that student nurses are given the opportunity to learn that their own feelings aroused in working with people with mental health problems can be used in a therapeutic way. Taking time to explore feelings and reflect on the interaction with a person suffering from mental ill health enhances understanding and develops more effective ways of relating. The teaching and learning groups with peers and the Lecturer/Practitioner in Practice Education can be a secure system for exploration and learning.

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Box 4

Students in Year 1 used the groups to work through their own anxieties about engaging in a nursing relationship with mentally ill people. Many students in this group had a similar range of stigmatising ideas. These were related to the level of danger that they may encounter from psychiatric service users, and the inevitability that the mentally ill will remain ill for the rest of their lives without hope of cure. This applied particularly to service users who had psychotic illnesses.

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Box 2

The main tool for teaching in practice is a reflective group process where students gather together to support, educate and assist each other to manage their learning. These groups are set up with a specific set of ground rules, which are generated by the students with support from the practice educator. This understanding of boundaries is an essential part in enabling students to reflect within a safe environment on their work. The core ground rules are built around the concepts of confidentiality, valuing others and demonstrating respect. Opportunities are taken to highlight parallels between the developing internal dynamics of the groups and the development of relationships with patients; so that how students are with each other form a model of how they can be with patients in clinical areas. The basic assumption being that patients respond to the development of relationships with others in a similar anxiety laden way as do students. So learning takes place from reflecting on the content and the developmental process of the group.

In the early stages of the student's training the group process is dominated by questions of 'how to do certain tasks that make me like my mentor' such as traditional nursing skills like injections, administering the mental health act and chairing ward rounds. The need for approval by the mentor in the form of doing tasks can get in the way of reflecting on what is it like for the students spending time with patients who are ill.

As students progress through their training there is an emerging level of maturity in their reflections. Inherent in the process of students articulating their reflections is the anxiety of feeling exposed and vulnerable. However as this anxiety is worked through the student's reflections contain a wider range of emotional reflections and the impact this has upon how they relate to the clinical environment and their patients.

Therefore in order to try and encourage a different way of thinking the students are taught to use a style of learning contract that focuses on the patients experiences and what can be learnt from understanding those experiences. For example rather than having as a learning objective knowing how to apply the Mental Health Act in a mechanical way, they would reflectively consider the impact of the Mental Health Act upon the nurse-patient relationship. In this case asking the question 'what is it like for the patients to be detained, to be nursed in a locked environment, and to be required to take medication?' So the aim of the contract is for the student to try and put themselves in the shoes of the patients, and understand what is happening from their perspective.

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Box 5

Many of the students and nurses, in the Community and on in-patient facilities, say they feel that they do not have time to do the job of nursing. They feel restricted by having to devote such a large proportion of the day engaged in administration, that they are unable to work on building therapeutic relationships with clients. The focus of my coaching sessions with more senior staff has been to demonstrate in practice how information gathering and building of a relationship can be part of the same activity.

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Box 6

In the first groups (in January) students struggled with the idea of reflecting upon their practice, yet 8-10 months later they seem to relish the process and valued the insights that reflection gave them. Areas chosen by the students included advocacy, potential abuses of service users human rights, managing perceived aggressive, the ethics of using control and restraint as a therapeutic intervention, the Snoozeland, stigma, the Mental Health Act, and whistle blowing. Some students presented journal articles that they had found interesting on the nurse-patient relationship.

As the groups matured, the depth and quality of their reflection also matured. There was less blaming of systems and other people and more ownership of their own emotional processes. The students began to talk less about their anxieties about organisational structures and more about their emotional responses to people who use psychiatric services. One aspect in particular was how they coped with the dying/dead patient, whether by disease or suicide. For many of the younger students their first encounter with death was as a student nurse. The group itself was able to recognise that this was a 'normal' response to the event, which seemed to be enough for them to be able to cope with the emotional discomfort that they experienced. Other emotional conflicts arose when students had negative feelings towards service users, for which they were unable to identify specific reasons. This presented the opportunity to introduce the ideas of transference and counter-transference. Although they were not always accepted as valid concepts, they did strike a cord as a way of explaining what was happening on an emotional level.

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scales and difficult sections of pieces with the specific intent of becoming a better musician. The first is performing; the second is developing capability (Ericsson, Krampe, Tesch-Römer, 1993).

Deliberate small group teaching in workplace settings is among the solutions to 'causes for concern' referred to earlier in relation to NHS staff teaching. Better lines of communications are fostered by practice educators, there is an increased sense of access to academics and academic facilities, increased feedback and peer support with senior lecturers, and better information about pre- and post-registration education – these are some of the solutions for NHS staff that can be inexpensively and effectively provided by Practice Educators, who for their part endeavour to help harness the skills and talents of non-academic NHS clinical teachers for the further development of those mentors, assessors and practice supervisors.

What is deliberate about this is the overt exercise of raising awareness first in consciousness and then applying it to elicited students' experience, then rehearsing in the 'shadow' of qualified mentors before the next students' group with a practice educator. The simple performance of a task, if it occurs frequently enough may maintain skill levels, but interpersonal teaching of skills is a key to advancing capability, because performance alone (referring back to our analogy between performing and practised musicians) is unlikely to achieve sufficient fitness for purpose in either teacher or student. At the point when deliberate interpersonal teaching stops, improvement in capability for clinical practice will stop too. Reflection on and adaptation of one's thinking and emotional processes is important; this will be maximised by seeking out opportunities to engage in trial and error in low risk settings.

Dynamic or interpersonal teaching and learning that involves student and staff learners is more complicated than the static tasks of practice education that requires more time and more improvisation by the teacher. This is the case for example when teaching and learning appears to be compromised as the result of organisational changes or staffing tensions arising for instance from unexpected mentor vacancies. Dynamic tasks would be characterised by differences across situations, by variations in the exact nature of the task and therefore by variations in the performance required from one time to the next. Dynamic tasks will require the individual to decide on appropriate strategies and adapt to various contingencies (Box 5, 6).

Practice Educators are re-mapping our thoughts about teaching and educational curricula, helping to prepare us for the inter-professional teaching. Our Faculty of Health is committed to undergraduate and postgraduate shared learning from 2004. Practical knowledge is at the heart of the shared learning agenda for us in mental health. It is based on personal tacit knowledge (Burnard, 1992, Polanyi, 1958), i.e. practice based skill and knowledge, articulated by practitioners who are NHS or University College staff and who use deliberate interpersonal teaching. For example, today Practice Educators will take the unspoken knowledge arising from practice, testing the claims in their small group clinical teaching as legitimate knowledge. Students and practitioners share the responsibility of generating knowledge and bringing to consciousness a recognition or consensus in their group work of the relationship between knowing and doing, between theory and practice, between constraints and opportunity, between unanimity and dissonance, e.g. is the 'orchestra' in tune. The transformation and formulation of implicit or tacit practice knowledge into articulated or demonstrated professional craft is what the Practice Educators are about – integrating the knowledge-practice relationship and increasing capability for assessment, mentorship, and supervision in mental health and social care student placements.

Intellectual assets and behavioural change

Intellectual capital is arguably the most important asset of the NHS, and its higher education partners. The establishment of work-based teaching by practice educators provides a useful order in which personal knowledge is given a coherent form (e.g. a description of a process, a meeting with a mentor, evidence obtained to support a clinical intervention). Tacit knowledge tends to be local because it is not found in manuals, books, databases, or files. Because tacit knowledge is usually unexpressed it's often unexamined. It is therefore being elicited orally and it is that individual and combined asset of students and staff that when shared is given form in deliberate interpersonal teaching. Because what was inexplicit becomes explicit, that change can lead to practical or behavioural change because new

knowledge (for instance from the examples above) is soaked in and becomes tacit. Another reason for investing in practice education is that 'human capital' matters because it is a source of innovation and renewal in the process of teaching and learning.

Beyond basic skills, what form of teaching can a dynamic performer engage in to develop or to begin to develop learning in these high order processes based on bringing to consciousness thinking and emotional reactions for use in professional responses, rather than automatic personal reactions. It may be helpful in replying to this question to consider a purely cognitive task requiring dynamic expertise, such as chess. How could chess players engage in interpersonal teaching? One possibility would be for colleagues to discuss problem scenarios. Alternatively, the aspiring students and teachers could agree to take moves back in order to explore how things might have developed if alternate choices were made. And this is a strategy too in deliberate interpersonal teaching. There is in this deliberate interpersonal client-centred practice education initiative an integral element of continuing professional development for all those involved.

Conclusion

Local clinical practice (Lemmer 2002) suggests that most individuals do not have an opportunity to engage in interpersonal teaching, or explore new methods. Rather, once they have obtained a minimally acceptable level of performance, they tend to favour well-entrenched activities and tend to avoid practice (e.g. after Ericsson K, 1996). Such lack of self-awareness can impact on a practitioner's performance (Kruger and Dunning, 1999).

We have aimed to describe a particular form of practice teaching that opens up an internal dialogue between the students' experiential mind and the intellectual mind. Providing a setting for students in which real life cases can be thought about and understood helps students to develop more effective ways of relating to service users. The relationship between knowing and doing is strengthened through bringing into conscious awareness thoughts and feelings about practice situations. This deliberate, interpersonal teaching approach

allows for the integration of person, knowledge and skills. Students are helped to develop an internal framework for a considered and professional response to service users.

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